		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0014753

Facility Name: TWIN WILLOWS NURSING CENTER

Address: P.O. BOX 370, ROUTE 37 NORTH (Number) SALEM (City) 62881 (Zip Code)

County: MARION

Telephone Number: (618) 548-0542 **Fax #** (618) 548-5893

IDPA ID Number: 37-098-7942001

Date of Initial License for Current Owners: 5/2/73

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: TODD WOODRUFF **Telephone Number:** (618) 548-0542

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-1-03 to 12-31-03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 7-24-04 (Date)
(Type or Print Name) TODD CURTIS WOODRUFF
(Title) ADMINISTRATOR

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 76

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	76	Intermediate (ICF)	76	27,740	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,740	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	14,829	3,078		17,907	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,829	3,078		17,907	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 64.55%

D. How many bed-hold days during this year were paid by Public Aid? (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES [X] NO [ ]

I. On what date did you start providing long term care at this location? Date started 01/01/73

J. Was the facility purchased or leased after January 1, 1978? YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year? YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 01/01/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	105,439	16,887	4,031	126,357		126,357		126,357			1
2	Food Purchase		121,175		121,175		121,175	(6,078)	115,097			2
3	Housekeeping	39,389	5,105		44,494		44,494		44,494			3
4	Laundry	20,884	6,788		27,672		27,672		27,672			4
5	Heat and Other Utilities			48,222	48,222		48,222	(2,000)	46,222			5
6	Maintenance	24,894	8,433	11,090	44,417		44,417		44,417			6
7	Other (specify):*											7
8	**TOTAL General Services**	190,606	158,388	63,343	412,337		412,337	(8,078)	404,259			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	540,272	47,958	6,900	595,130		595,130	(119)	595,011			10
10a	Therapy											10a
11	Activities	18,192	3,485		21,677		21,677		21,677			11
12	Social Services	12,798		4,437	17,235		17,235		17,235			12
13	Nurse Aide Training	4,910	730	2,120	7,760		7,760		7,760			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	576,172	52,173	13,457	641,802		641,802	(119)	641,683			16
	C. General Administration											
17	Administrative	45,000			45,000		45,000		45,000			17
18	Directors Fees											18
19	Professional Services			42,992	42,992		42,992	(24,935)	18,057			19
20	Dues, Fees, Subscriptions & Promotions			4,975	4,975		4,975		4,975			20
21	Clerical & General Office Expenses		9,278	3,884	13,162		13,162		13,162			21
22	Employee Benefits & Payroll Taxes			108,091	108,091		108,091		108,091			22
23	Inservice Training & Education			260	260		260		260			23
24	Travel and Seminar			1,839	1,839		1,839		1,839			24
25	Other Admin. Staff Transportation			1,044	1,044		1,044		1,044			25
26	Insurance-Prop.Liab.Malpractice			42,899	42,899		42,899		42,899			26
27	Other (specify):*											27
28	**TOTAL General Administration**	45,000	9,278	205,984	260,262		260,262	(24,935)	235,327			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	811,778	219,839	282,784	1,314,401		1,314,401	(33,132)	1,281,269			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER #0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			33,871	33,871		33,871		33,871			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			23,543	23,543		23,543	(9,556)	13,987			32
33	Real Estate Taxes			26,356	26,356		26,356		26,356			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			1,200	1,200		1,200		1,200			36
37	**TOTAL Ownership**			84,970	84,970		84,970	(9,556)	75,414			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		6,732		6,732		6,732		6,732			41
42	Provider Participation Fee			41,610	41,610		41,610		41,610			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		6,732	41,610	48,342		48,342		48,342			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	811,778	226,571	409,364	1,447,713		1,447,713	(42,688)	1,405,025			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	5,974	2-7		4
5	Telephone, TV & Radio in Resident Rooms	2,000	5-7		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	119	10-7		7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	7,223	32-7		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	104	2-7		13
14	Non-Care Related Interest	2,333	32-7		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	24,935	19-7		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 42,688		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 42,688		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

TWIN WILLOWS NURSING CENTER

ID# 0014753

Report Period Beginning: 1-1-03

Ending: 12-31-03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TWIN WILLOWS NURSING CENTER **#** 0014753 **Report Period Beginning:** 1-1-03 **Ending:** 12-31-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 **Report Period Beginning:** 1-1-03 **Ending:** 12-31-03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	0	0	0	0	0	0	0	0	0	0	0	0	45

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
HELEN WOODRUFF	95			MOTEL DEVEL	SALEM	MOTEL
JEFFREY WOODRUFF	5			WOODRUFF SVS	CARBONDALE	AC/HEATING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V		OFFICE STORAGE	1,200	MOTEL DEVELOPMENTS	100.00%	1,200		2
3	V		INTEREST	19,840	TODD WOODRUFF	0.00%	19,840		3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 21,040			$ 21,040	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	TODD WOODRUFF	ADMINISTRATOR	MANAGEMENT			60	100.00	INTEREST	$ 19,840	32	1
2	TODD WOODRUFF	ADMINISTRATOR	MANAGEMENT			60	100.00	WAGES	45,000	17	2
3	HELEN WOODRUFF	AUDIT ACCTNG	AUDIT ACCTNG	95.00		20	30.00	FEES	17,747	19	3
4	HUBERT WOODRUFF	ATTORNEY	LEGAL			5	10.00	FEES	24,775	19	4
5	JEFFREY WOODRUFF	WOODRUFF SVS	HEATING/AC	5.00							5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 107,362		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	BONDS			WORKING CAPITAL		11/2/72	$ 8,000	$ 8,000	12-31-84	10.0000	$ 800	1
2	BONDS			PURCHASING FACILITY		11/2/72	36,450	5,150	12-31-84	10.0000	515	2
3	TODD WOODRUFF	X		WORKING CAPITAL		1/87	226,744	246,584	12-31-03	0.0875	19,840	3
4												4
5												5
	Working Capital											
6	FINANCING CHARGES			ACCOUNTS PAYABLE							55	6
7	DISCOUNTS PAYABLE											7
8												8
9	TOTAL Facility Related						$ 271,194	$ 259,734			$ 21,210	9
	B. Non-Facility Related*											
10	MOTEL DEVELOPMENTS	X		PURCHASE OFFICE BLDG		4/1/86	56,000	28,999	12-31-03	0.0875	2,333	10
11				216 S BROADWAY								11
12												12
13												13
14	TOTAL Non-Facility Related						$ 56,000	$ 28,999			$ 2,333	14
15	TOTALS (line 9+line14)						$ 327,194	$ 288,733			$ 23,543	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	23,650	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	25,003	2
3. Under or (over) accrual (line 2 minus line 1).	$	(1,353)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	26,356	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	25,003	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	22,623	8
1999	23,673	9
2000	24,716	10
2001	24,406	11
2002	25,003	12

ESTIMATED BILL

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TWIN WILLOWS NURSING CENTER COUNTY MARION

FACILITY IDPH LICENSE NUMBER 0014753

CONTACT PERSON REGARDING THIS REPORT TODD WOODRUFF

TELEPHONE (618) 548-0542 FAX #: (618) 548-5893

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-02-000-027	PT SE NE	$ 25,002.56	$ 25,002.56
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 25,002.56	$ 25,002.56

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,205 B. General Construction Type: Exterior BRICK Frame FIREPROOF CONSTI Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	87,000	1973	$ 28,000	1
2					2
3	TOTALS	87,000		$ 28,000	3

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1973	1966	$ 380,183	$ 11,406	33 1/3	$ 11,406	$	$ 353,586	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	ROOF			1976							11
12	WATER HEATER			1977	1,024		10			1,024	12
13	FIRE EXIT LIGHTS			1978	695		5			695	13
14	EMERGENCY POWER			1978	1,695		5			1,695	14
15	EMERGENCY POWER			1979	1,359		5			1,359	15
16	COMPRESSOR			1979	372		5			372	16
17	BATTERY UNITS			1980	570		3			570	17
18	COMPRESSOR			1980	533		5			533	18
19	MIXING VALVE			1981	780		10			780	19
20	CENTRAL AIR			1981	771		10			771	20
21	DISPOSAL KITCHEN			1982	745		10			745	21
22	STORAGE SHED			1982	600		8			600	22
23	3 HEAT PUMPS			1983	2,245		10			2,245	23
24	PHONE SYSTEM			1985	3,318		20			3,318	24
25	2 HEAT PUMPS			1985	1,400		8			1,400	25
26	DRIVEWAY			1988	2,767		3			2,767	26
27	SEAL COAT-PATCH DRIVEWAY			1997	1,850		3			1,850	27
28	DOOR MONITOR SYSTEM			1999	7,590	759	10	759		3,226	28
29	3 CENTRAL AIR SYSTEMS-3T			1999	12,588	2,518	5	2,518		10,386	29
30	REPLACEMENT ROOF			1999	64,580	4,305	15	4,305		17,579	30
31	ASPHALT TOP COAT DRIVEWAY			1999	16,136	2,017	8	2,017		8,320	31
32	OUTSIDE WALKWAY LIGHTS			1999	600	120	5	120		535	32
33	REPLACE SOUTH WING SEWER LINE			2000	1,046	105	10	105		376	33
34	REPLACE THREE OUTSIDE HYDRANTS			2000	525	52	10	52		160	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 503,972	$ 21,282		$ 21,282	$	$ 414,892	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 116,839	$ 11,809	$ 11,809	$		$ 66,132	71
72	Current Year Purchases	14,086	554	554		9:33	554	72
73	Fully Depreciated Assets	90,294	226	226			90,294	73
74								74
75	TOTALS	$ 221,219	$ 12,589	$ 12,589	$		$ 156,980	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		WAGON	1987	$ 10,990	$	$	$	4	$ 10,990	76
77										77
78										78
79										79
80	TOTALS			$ 10,990	$	$	$		$ 10,990	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 764,181	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 33,871	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 33,871	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 582,862	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	ALUMINUM TRAILER	$ 10,000	$	$ 10,000	86
87	216 S BROADWAY	56,000		56,000	87
88	??	19,807	501	12,063	88
89	DRIVEWAY 216	6,119	285	2,751	89
90					90
91	TOTALS	$ 91,926	$ 786	$ 80,814	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 1,200			3
4	Additions							4
5								5
6								6
7	TOTAL				$ 1,200 **			7

10. Effective dates of current rental agreement:
Beginning 01/01/03
Ending 12/31/03

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$ 1,200
13.	/2005	$
14.	/2006	$

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$ 1,820	$	$ 1,820
2	Books and Supplies		46	684		730
3	Classroom Wages	(a)	288	3,360		3,648
4	Clinical Wages	(b)		1,262		1,262
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests			300		300
9	TOTALS		$ 334	$ 7,426	$	$ 7,760
10	SUM OF line 9, col. 1 and 2	(e)	$ 7,760			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	6
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	6

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER **#** 0014753 **Report Period Beginning:** 1-1-03 **Ending:** 12-31-03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12-31-03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 184,578	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	277,041		3
4	Supply Inventory (priced at)	12,500		4
5	Short-Term Investments	33,382		5
6	Prepaid Insurance	23,352		6
7	Other Prepaid Expenses	10,795		7
8	Accounts Receivable (owners or related parties)	20,254		8
9	Other(specify): 1120 TAX DEPOSITS	24,552		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 586,454	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	135,147		11
12	Long-Term Investments			12
13	Land	32,000		13
14	Buildings, at Historical Cost	436,183		14
15	Leasehold Improvements, at Historical Cost	88,807		15
16	Equipment, at Historical Cost	303,428		16
17	Accumulated Depreciation (book methods)	(661,894)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 333,671	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 920,125	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 44,545	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	22,310		30
31	Accrued Taxes Payable (excluding real estate taxes)	5,703		31
32	Accrued Real Estate Taxes(Sch.IX-B)	26,356		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 98,914	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	430,318		39
40	Mortgage Payable			40
41	Bonds Payable	13,150		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	STOCK	3,500		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 446,968	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 545,882	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 374,243	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 920,125	$	48

***(See instructions.)**

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 575,844	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 575,844	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(164,669)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) TAX PAYMENT 99	(17,694)	15
16	Other (describe) ADJ-ADL DEPRECIT NON ? ASSETS	(19,238)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (201,601)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 374,243	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,276,826	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,276,826	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	5,039	11
12	Gift and Coffee Shop	7,102	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	5,832	14
15	Telephone, Television and Radio	1,070	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	320	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 19,363	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	6,043	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 6,043	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	216 RENTAL	7,200	28
28a	WORKMEN COMP REFUND	2,514	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 9,714	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,311,946	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	404,259	31
32	Health Care	641,683	32
33	General Administration	235,327	33
	B. Capital Expense		
34	Ownership	75,414	34
	C. Ancillary Expense		
35	Special Cost Centers	6,732	35
36	Provider Participation Fee	41,610	36
	D. Other Expenses (specify):		
37			37
38			38
39	SEE SCHEDULE FOR OTHER DEDUCTIONS		39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,405,025	40
41	**Income before Income Taxes (line 30 minus line 40)****	(93,079)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (164,669)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,181	2,332	$ 49,072	$ 21.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	4,495	4,880	79,430	16.28	3
4	Licensed Practical Nurses	9,342	9,945	145,063	14.59	4
5	Nurse Aides & Orderlies	37,008	38,172	254,248	6.66	5
6	Nurse Aide Trainees	837	837	4,910	5.87	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,411	1,526	10,341	6.78	8
9	Activity Director	1,276	1,276	7,851	6.15	9
10	Activity Assistants	1,527	1,829	12,798	7.00	10
11	Social Service Workers					11
12	Dietician	2,912	3,259	26,500	8.13	12
13	Food Service Supervisor					13
14	Head Cook	6,198	6,489	39,025	6.01	14
15	Cook Helpers/Assistants	6,141	6,532	39,914	6.11	15
16	Dishwashers	1,672	2,090	24,894	11.91	16
17	Maintenance Workers	5,884	6,460	39,389	6.10	17
18	Housekeepers	2,939	3,208	20,884	6.51	18
19	Laundry	2,912	3,000	45,000	15.00	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,673	1,809	12,459	6.89	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,408	93,644	$ 811,778 *	$ 8.67	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	82	$ 4,031	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	45	1,500	10-3	39
40	Physical Therapy Consultant	42	4,200	10-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	39	4,437	12-3	45
46	Other(specify)				46
47	ADVISORY PHYSICIAN	12	1,200	10-3	47
48					48
49	TOTAL (lines 35 - 48)	220	$ 15,368		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
TODD WOODRUFF			$ 45,000
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 45,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
HUBERT WOODRUFF	LEGAL MANAGEMENT	$ 24,775
HELEN WOODRUFF	AUDIT ACCOUNTING	17,747
H & R BLOCK		310
LEGAL		160
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 42,992

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 35,876
Unemployment Compensation Insurance	6,657
FICA Taxes	62,060
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
XMAS	2,528
EMPLOYEE RECOGNITION	82
BOTTLE WATER	888
TOTAL (agree to Schedule V, line 22, col.8)	$ 108,091

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	702
Health Care Worker Background Check	
(Indicate # of checks performed 28)	420
IHCA	3,268
IL SECT STATE	50
MES	234
NFIB	101
Less: Public Relations Expense	( )
Non-allowable advertising	(5,493)
Yellow page advertising	(7,641)
TOTAL (agree to Sch. V, line 20, col. 8)	$ (8,159)

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	319
Seminar Expense	1,520
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,839

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number TWIN WILLOWS NURSING CENTER # 0014753 Report Period Beginning: 1-1-03 Ending: 12-31-03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA 3268**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **9.33**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **14,823** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,610**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **YES** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **3,388**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **LESS THAN**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NONE DONE**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.